

PHYSICAL THERAPY PROTOCOL

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A. Physical Therapy Assessment

1. Is the service recipient age 21 years or older?

If **YES**, proceed to Question #2.

If **NO**, skip to Question #9.
2. Is this a new assessment for environmental accessibility (i.e., home) modifications?

If **YES**, skip to Question #7.

If **NO**, proceed to Question #3.
3. Is the assessment needed in order to determine the need for treatment of a medical condition or functional deficit involving ambulation and mobility that is related to an injury, illness, or hospitalization occurring within the past 90 days?

If **YES**, proceed to Question #4.

If **NO**, skip to Question #5.
4. Was a request for a Physical Therapy assessment denied through the TennCare MCO fair hearing process and, if applicable, denied or not covered by Medicare?

If **YES**, proceed to Question #5.

If **NO**, stop and deny based on the waiver being the **payor of last resort**, unless the service recipient is **currently** receiving waiver-funded Physical Therapy and is requesting all of the Physical Therapy to be provided through the waiver by the same provider. If the latter, proceed to Question #5. Otherwise, deny and include the following statement in the denial letter: "Medically necessary Physical Therapy services to restore lost function are covered for adults age 21 and older under the TennCare Program. Federal law says that we can't pay for care under the waiver that is covered under the TennCare Program [42 CFR, Section 440.180; State Medicaid Manual, Section 4442.1]."
5. Is the request for an initial assessment after enrollment in the waiver or after an interval of *at least* 12 months since the last Physical Therapy assessment?

If **YES**, skip to Question #7.

If **NO**, proceed to Question #6.

6. Is a new Physical Therapy assessment needed because:

- a. The service recipient was discharged from services by a physical therapist who withdrew from participation as a waiver services provider; **OR**
- b. The service recipient is currently receiving waiver-funded Physical Therapy and has now developed an acute need for additional services to restore lost function. Such additional services would normally be provided by the MCO, but to ensure coordination, all of the Physical Therapy will be provided through the waiver by the same provider.

If **YES**, proceed to Question #7.

If **NO**, skip to Question #8.

7. Medical necessity review questions:

- a. Is there an order by a physician, physician assistant, or nurse practitioner for the Physical Therapy assessment; **AND**
- b. Is there sufficient information in the Individual Support Plan (ISP) to document that the service recipient has a medical diagnosis or functional deficit involving ambulation and mobility; **AND**
- c. Is there sufficient information in the Individual Support Plan (ISP) to conclude that, based on the service recipient's medical diagnosis or functional deficit involving ambulation and mobility, the service recipient's functional and/or treatment needs cannot be adequately determined without a new Physical Therapy assessment?

If **YES to all three** of the criteria specified in "7.a" through "7.c" above, skip to Question #11.

If **NO to any** criterion specified in "7.a" through "7.c" above, stop and deny as **not medically necessary**. All of the unmet medical necessity criteria from "7.a" through "7.c" above and the applicable prongs of medical necessity must be specified in the denial letter. Applicable prongs of medical necessity may include:

- "Not ordered by a doctor" ("7.a");
- "Not necessary to treat" ("7.b" and "7.c");
- "Not safe and effective" (*"The type, scope, frequency, intensity, and duration of a medical item or service must not be in excess of the enrollee's needs."*) ("7.b" and "7.c"); and
- "Not the least costly adequate alternative" ("7.b" and "7.c").

NOTE: To the extent there is a covered, medically necessary alternative, such service will be specified in the denial notice.

8. Medical necessity review questions:

- a. Is there an order by a physician, physician assistant, or nurse practitioner for the Physical Therapy assessment; **AND**
- b. Is there sufficient information in the Individual Support Plan (ISP) to document that:

- (1) The service recipient has a new medical diagnosis or functional deficit involving ambulation and mobility; **OR**;
 - (2) The service recipient has experienced a significant exacerbation of a pre-existing medical condition or functional deficit after having been discharged from Physical Therapy services by the physical therapist; **AND**
- c. Is there sufficient information in the Individual Support Plan (ISP) to conclude that, based on the service recipient's medical diagnosis or functional deficit involving ambulation and mobility, the service recipient's functional and/or treatment needs cannot be adequately determined without a new Physical Therapy assessment?

If **YES to all three** of the criteria specified in "8.a" through "8.c" above, skip to Question #11.

If **NO to any** criterion specified in "8.a" through "8.c" above, stop and deny as not medically necessary. All of the unmet medical necessity criteria from "8.a" through "8.c" above and the applicable prongs of medical necessity must be specified in the denial letter. "Applicable prongs of medical necessity may include:

- "Not ordered by a doctor ("8.a");
- "Not necessary to treat" ("8.b" and "8.c");
- "Not safe and effective" (*"The type, scope, frequency, intensity, and duration of a medical item or service must not be in excess of the enrollee's needs."*) ("8.b" and "8.c"); and
- "Not the least costly adequate alternative" ("8.b" and "8.c").

NOTE: To the extent there is a covered, medically necessary alternative, such service will be specified in the denial notice.

9. Is this a new assessment for environmental accessibility (i.e, home) modifications?

If **YES**, proceed to Question #10.

If **NO**, stop and deny based on the waiver being the payor of last resort. Include the following statement in the denial letter: "Medically necessary Physical Therapy services are covered under the TennCare Program for children under age 21. Federal law says that we can't pay for care under the waiver that is covered under the TennCare Program [42 CFR, Section 440.180; State Medicaid Manual, Section 4442.1]."

10. Medical necessity review questions:

- a. Is there an order by a physician, physician assistant, or nurse practitioner for the Physical Therapy assessment; **AND**
- b. Is there sufficient information in the Individual Support Plan (ISP) to document that the service recipient has a medical diagnosis or functional deficit involving ambulation and mobility; **AND**
- c. Is there sufficient information in the Individual Support Plan (ISP) to conclude that, based on the service recipient's medical diagnosis or functional deficit involving ambulation and mobility, the service recipient's functional and/or treatment needs (in the case of a child under age 21, the need for environmental accessibility modifications) cannot be adequately determined without a new Physical Therapy assessment?

If **YES to all three** of the criteria specified in "10.a" through "10.c" above, proceed to Question #11.

If **NO** to *any* criterion specified in “10.a” through “10.c” above, stop and deny as **not medically necessary**. All of the unmet medical necessity criteria from “10.a” through “10.c” above and the applicable prongs of medical necessity must be specified in the denial letter. Applicable prongs of medical necessity may include:

- “Not ordered by a doctor” (“10.a”);
- “Not necessary to treat” (“10.b” and “10.c”);
- “Not safe and effective” (“*The type, scope, frequency, intensity, and duration of a medical item or service must not be in excess of the enrollee’s needs.*”) (“10.b” and “10.c”); and
- “Not the least costly adequate alternative” (“10.b” and “10.c”).

NOTE: To the extent there is a covered, medically necessary alternative, such service will be specified in the denial notice.

11. Has the waiver limit of three (3) Physical Therapy assessments per waiver program year per provider been exceeded for the current program year?

If **YES**, stop and deny as a **non-covered service** based on the waiver service limit of three (3) assessments per service recipient per provider per program year.

If **NO**, stop and approve the Physical Therapy assessment.

B. Initial Physical Therapy Services (excluding assessment)

(NOTE: This section applies to service recipients who are **not** currently approved for Physical Therapy services through the waiver.)

1. Is the service recipient age 21 years or older?

If **YES**, proceed to Question #2.

If **NO**, stop and deny based on the waiver being the **payor of last resort**. Include the following statement in the denial letter: “Medically necessary Physical Therapy Services are covered under the TennCare Program for children under age 21. Federal law says that we can’t pay for care under the waiver that is covered under the TennCare Program [42 CFR, Section 440.180; State Medicaid Manual, Section 4442.1].”

2. Is Physical Therapy needed in order to restore lost function due to a medical condition or functional deficit involving ambulation and mobility that is related to an injury, illness, or hospitalization occurring within the past 90 days?

If **YES**, proceed to Question #3.

If **NO**, skip to Question #4.

3. Was a request for Physical Therapy denied through the TennCare MCO fair hearing process and, if applicable, denied or not covered by Medicare?

If **YES**, proceed to Question #4.

If **NO**, stop and deny based on the waiver being the **payor of last resort**. Include the following statement in the denial letter: “Medically necessary Physical Therapy services to

restore lost function are covered for adults age 21 and older under the TennCare Program. Federal law says that we can't pay for care under the waiver that is covered under the TennCare Program [42 CFR, Section 440.180; State Medicaid Manual, Section 4442.1]."

4. Medical necessity review questions:

- a. Is there an order by a physician, physician assistant, or nurse practitioner for the Physical Therapy, **AND**
- b. Is there sufficient information in the Individual Support Plan (ISP) to document that the service recipient has a medical diagnosis or functional deficit involving ambulation and mobility; **AND**
- c. Is there sufficient information in the ISP and/or supporting documentation (e.g., the therapy plan of care) to conclude that the service recipient's functional and/or treatment needs involving ambulation and mobility cannot be adequately met unless Physical Therapy is provided by a licensed physical therapist or physical therapy assistant working under the supervision of a licensed physical therapist (i.e., paid and unpaid caregivers would not otherwise be able to adequately meet the specified functional or treatment needs); **AND**
- d. Is there sufficient documentation in the ISP and/or supporting documentation to conclude that the provision of Physical Therapy services can be reasonably expected to (1) achieve measurable and sustained functional gains for the service recipient; (2) maintain current functional abilities that would be lost without the provision of Physical Therapy Services; or (3) prevent or minimize the deterioration of a chronic condition that would result in the further loss of function or the imminent development of serious medical problems); **AND**
- e. Are there clearly defined measurable Physical Therapy goals in the ISP and/or supporting documentation which are reasonable and appropriate given the person's current age and health status?

If **YES to all five** of the criteria specified in "4.a" through "4.e" above, proceed to Question #5.

If **NO to any** criterion specified in "4.a" through "4.e" above, stop and deny as **not medically necessary**. All of the unmet medical necessity criteria from "4.a" through "4.e" above and the applicable prongs of medical necessity must be specified in the denial letter. Applicable prongs of medical necessity may include:

- "Not ordered by a doctor" ("4.a");
- "Not necessary to treat" ("4.b" through "4.e")
- "Not safe and effective" ("*The type, scope, frequency, intensity, and duration of a medical item or service must not be in excess of the enrollee's needs.*") ("4.b" through "4.e"); and
- "Not the least costly adequate alternative" ("4.b" through "4.e").

5. Is the frequency (per week, per month, etc.), amount (# of units) and duration (# of weeks or months) of Physical Therapy Services requested *consistent with* and not *in excess of* the amount of services needed to (1) achieve measurable and sustained functional gains; (2) maintain current functional abilities; or (3) prevent or minimize the deterioration of a chronic condition as specified in "4.d" above?

NOTE: To the maximum extent possible and appropriate, Physical Therapy Services by a licensed physical therapist or licensed physical therapy assistant working under the supervision of a licensed physical therapist should be utilized to develop a treatment plan that can be implemented by caregivers (including, but not limited to family members, paid personal assistants, and residential services staff), across activities and settings in order to

achieve the maximum therapeutic benefit. Periodic services by the licensed physical therapist or licensed physical therapy assistant working under the supervision of a licensed physical therapist should be authorized *only* as necessary to support the ongoing implementation of the treatment plan, or to modify the treatment plan in response to the changing needs of the service recipient.

If **YES**, stop and approve the amount of Physical Therapy Services requested. Such approval may specify that concurrent review will be conducted after a specified period of time (see attached guidelines) to ensure that Physical Therapy Services continue to be medically necessary. Such determination shall be based on current medical records provided by the licensed professional and/or physician, physician assistant, or nurse practitioner in response to the request for concurrent review.

If **NO**, approve that portion of the total amount of Physical Therapy Services requested that is *consistent with* the amount of Physical Therapy Services needed to (1) achieve measurable and sustained functional gains; (2) maintain current functional abilities; or (3) prevent or minimize the deterioration of a chronic condition as specified in “4.d” above. Deny as **not medically necessary** that portion of the total amount of Physical Therapy Services requested that is *in excess of* the amount of services needed to (1) achieve measurable and sustained functional gains; (2) maintain current functional abilities; or (3) prevent or minimize the deterioration of a chronic condition as specified in “4.d” above. The unmet medical necessity criteria and the applicable prongs of medical necessity must be specified in the denial letter. Applicable prongs of medical necessity may include:

- “Not necessary to treat;”
- “Not safe and effective” (“*The type, scope, frequency, intensity, and duration of a medical item or service must not be in excess of the enrollee’s needs.*”); and
- “Not the least costly adequate alternative.”

If Physical Therapy Services are approved for lesser duration of service than requested, include the following in the denial letter: “Based on the medical records we have now, we can only tell that you need this care for ____ days. We must see if the care we have approved helps you before we can decide if you need more care. What if you think you will need this care for *more* than ____ days? Before the ____ days are over, your doctor can ask for more care. OR, if you think your *current* medical records already show that you will need the care for *more* than ____ days, you can appeal.

C. Continuation of Physical Therapy Services (excluding assessment)

(NOTE: This section applies to service recipients who are *currently* approved for Physical Therapy (PT) services through the waiver and who request *continuation* of PT or an *increase* in PT.)

(NOTE: To ensure coordination of ongoing services, if a service recipient age 21 and older is already receiving waiver-funded PT Services and also develops an acute need for additional PT Services in order to restore lost function that would otherwise be provided by the MCO, the additional PT Services may be approved through the waiver if medically justified, so that all of the PT Services would be provided through the waiver by the same provider.)

1. Is the service recipient age 20 years or older?

NOTE: If a service recipient is age 20 years (but not yet age 21), transition of Physical Therapy Services to the TennCare MCO will **not** be initiated since transition back to waiver services would likely be required upon attaining 21 years of age.

If **YES**, skip to Question #3.

If **NO**, proceed to Question #2.

2. Is the request for an *increase* in the frequency (per week, per month, etc.) or amount (# of units) of Physical Therapy Services?

If **YES**, **deny** the requested **increase** in the frequency or amount of Physical Therapy Services based on the waiver being the **payor of last resort**. **Approve** the **continuation** of Physical Therapy Services at the *current* level pending transition of medically necessary Physical Therapy Services to the TennCare MCO. Include the following statement in the denial letter: "Medically necessary Physical Therapy Services are covered under the TennCare Program for children under age 21. For now, we'll keep paying for the same amount of care you've been getting while we work with your MCO to take over **all** of your medically necessary Physical Therapy Services. BUT, we can't pay for more waiver services than you've been getting. If you need more Physical Therapy Services, you must ask your MCO to pay for them. Your MCO will pay for medically necessary Physical Therapy Services. Federal law says that we can't pay for care under the waiver that is covered under the TennCare Program [42 CFR, Section 440.180; State Medicaid Manual, Section 4442.1]."

In order to facilitate a coordinated approach to the delivery of Physical Therapy Services, if an increase is requested and denied, initiate the process for transition of the *currently* approved level of Physical Therapy Services to the MCO as specified below.

If **NO**, or upon denial of a requested **increase** in the frequency or amount of Physical Therapy Services as noted above, initiate the process for transition of **all** medically necessary Physical Therapy Services to the TennCare Managed Care Organization (MCO) as follows:

- a. Approve the *continuation* of Physical Therapy at the *current* level pending transition of medically necessary Physical Therapy to the TennCare MCO. **No increases** in **waiver** Physical Therapy Services should be authorized for children under age 20.
- b. Notify the service recipient's MCO regarding plans to transition Physical Therapy Services. Include in such notification a copy of all relevant medical information, including the order by a physician, physician assistant, or nurse practitioner for the Physical Therapy Services, a copy of the ISP, therapy assessment(s) and therapy plan(s) of care indicating the medical diagnosis or functional deficit involving ambulation and mobility, the purpose of currently authorized Physical Therapy Services (e.g., 1) to achieve measurable and sustained functional gains for the service recipient; 2) to maintain current functional abilities that would be lost without the continued provision of Physical Therapy Services; or 3) to prevent or minimize the deterioration of a chronic condition that would result in the further loss of function or the imminent development of serious medical problems), as well as measurable Physical Therapy goals, therapy notes and other documentation supporting the service recipient's progress in meeting these goals, and any requested *increase* in the *currently* approved level of Physical Therapy Services.
- c. The MCO may request additional medical information as needed from the treating physician and/or licensed therapy professional, and may complete an in-home evaluation in order to make an individualized determination regarding the amount of Physical Therapy Services that are medically necessary going forward. Accordingly and since such currently approved Physical Therapy Services are being provided under the waiver, the MCO may take additional time to make this determination and to arrange needed care. DMRS will notify TennCare regarding any unreasonable delays by the MCO in completing transition activities.

- d. Prior authorization of any requested *increase* in the currently approved level of Physical Therapy Services must be completed by the MCO within the applicable prior authorization timeline (not to exceed 14 days as specified in federal regulation).
- e. Coordinate with the MCO regarding the appropriate date to transition medically necessary care, as determined by the MCO. There should be **no gaps in service delivery**. The transition should not occur until a TennCare MCO provider is identified, all applicable pre-service activities are completed, and a *specific* date is determined that the provider can begin delivering medically necessary care as authorized by the MCO under the TennCare program. Such date must allow adequate time for advance notice of termination of Physical Therapy Services under the waiver.
- f. Issue *at least* 20 days advance notice (inclusive of mail time) of termination of **waiver** Physical Therapy Services, as applicable, indicating that the services will be terminated on the 21st day from the date of the notice or upon the specific date of transition to Physical Therapy Services by the MCO under the TennCare program, as applicable. The legal basis for such action is **payor of last resort**. Include the following statement in the denial letter: "Medically necessary Physical Therapy Services are covered under the TennCare Program for children under age 21. Federal law says that we can't pay for care under the waiver that is covered under the TennCare Program [42 CFR, Section 440.180; State Medicaid Manual, Section 4442.1]." The previously approved level of **waiver** Physical Therapy Services shall continue to be authorized and reimbursed pending such advance notice period.

The service recipient may file a timely appeal regarding the termination of **waiver** Physical Therapy Services within 40 days from the date of the notice (inclusive of mail time) or *any time prior* to the effective date of the action (i.e., the date that waiver Physical Therapy Services are terminated). If an appeal is received within 20 days from the date of notice (inclusive of mail time) or *any time prior* to the effective date of the action, the service recipient may request continuation of the previously approved **waiver** Physical Therapy Services pending resolution of the appeal, in which case such previously approved **waiver** Physical Therapy Services shall continue pending notification from TennCare that the appeal has been resolved and that continuation of benefits may be stopped.

- g. If the MCO denies the request for coverage of Physical Therapy based on medical necessity, issue a written notice of termination of Physical Therapy which states that the waiver is the payor of last resort and that the MCO has determined that the service is not medically necessary.

The service recipient may file a timely appeal regarding the termination of **waiver** Physical Therapy within 40 days from the date of the notice (inclusive of mail time) or *any time prior* to the effective date of the action (i.e., the date that waiver Physical Therapy are terminated). If an appeal is received within 20 days from the date of notice (inclusive of mail time) or *any time prior* to the effective date of the action, the service recipient may request continuation of the previously approved **waiver** Physical Therapy pending resolution of the appeal, in which case such previously approved **waiver** Physical Therapy shall continue pending notification from TennCare that the appeal has been resolved and that continuation of benefits may be stopped.

Include the following statement in the denial letter: "Medically necessary Physical Therapy are covered under the TennCare Program for children under age 21. Federal law says that we can't pay for care under the waiver that is covered under the TennCare Program [42 CFR, Section 440.180; State Medicaid Manual, Section 4442.1]."

3. Medical necessity review questions for *continuation* of the *currently* approved level of Physical Therapy Services for an adult service recipient age 20 or older plus any requested *increase* in such services, as applicable:
- Is there an order by a physician, physician assistant, or nurse practitioner for the Physical Therapy; **AND**
 - Is there sufficient information in the Individual Support Plan (ISP) to document that the service recipient continues to have a medical diagnosis or functional deficit involving ambulation and mobility; **AND**
 - Is there sufficient information in the ISP and/or supporting documentation (e.g., the therapy plan of care) to conclude that the service recipient's functional and/or treatment needs involving ambulation or mobility *still* cannot be adequately met unless Physical Therapy Services are provided by a licensed physical therapist or licensed physical therapy assistant working under the supervision of a licensed physical therapist (i.e., paid and unpaid caregivers would *still* not otherwise be able to adequately meet the specified functional or treatment needs); **AND**
 - Is there sufficient information in the ISP and/or supporting documentation to demonstrate:
 - Progress toward defined treatment goals in terms of measurable and sustained functional gains for the service recipient that can be generalized to settings outside the immediate treatment environment; **OR**
 - The continuing medical need for Physical Therapy Services in order to maintain current functional abilities that would be lost without the *continued* provision of Physical Therapy Services; **OR**
 - The *continuing* medical need for Physical Therapy Services in order to prevent or minimize the deterioration of a chronic condition that would result in the further loss of function or the imminent development of serious medical problems?
 - Are clearly defined measurable Physical Therapy Services goals as specified in the ISP and/or supporting documentation *still* reasonable and appropriate given the person's current age and health status?

If **YES to all five (5)** criteria specified in "3.a" through "3.e" above, proceed to question 4.

If **NO to any** criterion specified in "3.a" through "3.e" above, stop and deny as **not medically necessary**. All of the unmet medical necessity criteria from "3.a" through "3.e" above and the applicable prongs of medical necessity must be specified in the denial letter. Applicable prongs of medical necessity may include:

- "Not ordered by a doctor" ("3.a");
- "Not necessary to treat" ("3.b" through "3.e");
- "Not safe and effective" ("*The type, scope, frequency, intensity, and duration of a medical item or service must not be in excess of the enrollee's needs.*") ("3.b" through "3.e"); and
- "Not the least costly adequate alternative" ("3.b" through "3.e").

4. Is the frequency (per week, per month, etc.), amount (# of units) and duration (# of weeks or months) of *continued* Physical Therapy Services requested plus any requested increase in such services, as applicable, *consistent with* and not *in excess of* the amount of services *still* needed to (1) achieve measurable and sustained functional gains; (2) maintain current functional abilities; or (3) prevent or minimize the deterioration of a chronic condition as specified in "3.d" above?

To the extent that the request includes any increase in the frequency, amount, or duration of Physical Therapy Services, is there sufficient information in the ISP and/or supporting documentation to demonstrate that the service recipient's needs have changed and/or the previously approved frequency, amount, or duration of Physical Therapy Services is no longer sufficient to (a) achieve measurable and sustained functional gains for the service recipient that can be generalized to settings outside the immediate treatment environment; (b) maintain current functional abilities that would be lost without the continued provision of Physical Therapy Services; or (c) prevent or minimize the deterioration of a chronic condition that would result in the further loss of function or the imminent development of serious medical problems?

NOTE: To the maximum extent possible and appropriate, Physical Therapy Services by a licensed physical therapist or licensed physical therapy assistant working under the supervision of a licensed physical therapist should be utilized to develop a treatment plan that can be implemented by caregivers (including, but not limited to family members, paid personal assistants, and residential services staff), across activities and settings in order to achieve the maximum therapeutic benefit. Periodic services by the licensed physical therapist or licensed physical therapy assistant working under the supervision of a licensed physical therapist should be authorized *only* as necessary to support the ongoing implementation of the treatment plan, or to modify the treatment plan in response to the changing needs of the service recipient.

If **YES**, stop and approve the *continuation* of Physical Therapy Services and any *increase* as requested. Such approval may specify that concurrent review will be conducted after a specified period of time (see attached guidelines) to ensure that Physical Therapy Services continue to be medically necessary. Such determination shall be based on medical records provided by the licensed professional and/or physician, physician assistant, or nurse practitioner in response to the request for concurrent review.

If **NO**, approve that portion of the total amount of Physical Therapy Services requested that is *consistent with* the amount of Physical Therapy Services needed to (1) achieve measurable and sustained functional gains; (2) maintain current functional abilities; or (3) prevent or minimize the deterioration of a chronic condition as specified in "3.d" above.

- If the request for Physical Therapy Services was submitted as an ISP amendment or as an annual update of the ISP, **deny** as not medically necessary that portion of the total amount of Physical Therapy Services requested that is *in excess of* the amount of Physical Therapy Services needed to (1) achieve measurable and sustained functional gains; (2) maintain current functional abilities; or (3) prevent or minimize the deterioration of a chronic condition as specified in "3.d" above; **OR**
- If the protocol was used for a DMRS-initiated review of an ISP and cost plan (i.e., rather than review of an ISP amendment or annual ISP update), issue 20 days advance notice (inclusive of mail time) of reduction or termination of services, as applicable, indicating that the services will be reduced or terminated on the 21st day from the date of the notice. The previously approved Physical Therapy Services shall continue to be authorized and reimbursed pending such advance notice period.

The service recipient may file a timely appeal regarding the reduction/termination of Physical Therapy Services within 40 days from the date of the notice (inclusive of mail time) or *any time prior* to the effective date of the action (i.e., the date the services are reduced or terminated). If an appeal is received within 20 days from the date of notice (inclusive of mail time) or *any time prior* to the effective date of the action, the service recipient may request continuation of the previously approved Physical Therapy Services pending resolution of the appeal, in which case such previously approved Physical Therapy Services shall continue pending notification from TennCare that the appeal has been resolved and that continuation of benefits may be stopped.

The unmet medical necessity criteria and the applicable prongs of medical necessity must be specified in the denial letter. Applicable prongs of medical necessity may include:

- “Not necessary to treat;”
- “Not safe and effective” (*“The type, scope, frequency, intensity, and duration of a medical item or service must not be in excess of the enrollee’s needs.”*); and
- “Not the least costly adequate alternative.”

If *continuation* of Physical Therapy Services is approved for a lesser duration of service than requested, include the following in the denial letter: “Based on the medical records we have now, we can only tell that you need this care for ____ days. We must see if the care we have approved helps you before we can decide if you need more care. What if you think you will need this care for *more* than ____ days? Before the ____ days are over, your doctor can ask for more care. OR, if you think your *current* medical records already show that you will need the care for *more* than ____ days, you can appeal.